STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

AFFIDAVIT OF HEALTH CARE PRACTITIONER
Gender Transition Evaluation

THIS AFFIDAVIT MUST BE COMPLETED BY A LICENSED PHYSICIAN, ADVANCE PRACTICE REGISTERED NURSE OR PSYCHOLOGIST

I _____, _____ swear the following to be true:
Name of practitioner performing evaluation — Title (i.e., MD, APRN, Psychologist)

My Practicing Address is _____,

in the City of _____, State of _____.

I hold a current license in good standing from the State of _____ to
State

practice as a _____. My license
Physician, APRN, Psychologist

number is _____.
License #

I have evaluated _____,
Birth name

_____, _____, _____.
Legal name change, if applicable — Date of Birth — City and State of Birth

and conclude that the above named individual has undergone surgical, hormonal or other treatment clinically appropriate for gender transition, and that such individual's gender is

_____.
(Gender)

_____ _____
SIGNATURE OF PRACTITIONER PERFORMING EVALUATION — DATE OF EVALUATION

Subscribed and sworn to before me this _____ day of _____, 20_____

_____
NOTARY PUBLIC

(SEAL)

_____
EXPIRATION DATE